A Qualitative Study of Determinants of PTSD Treatment Initiation in Veterans

Nina A. Sayer, Greta Friedemann-Sanchez, Michele Spoont, Maureen Murdoch, Louise E. Parker, Christine Chiros, and Robert Rosenheck

Although there are effective treatments for Posttraumatic Stress Disorder (PTSD), many PTSD sufferers wait years to decades before seeking professional help, if they seek it at all. An understanding of factors affecting treatment initiation for PTSD can inform strategies to promote help-seeking. We conducted a qualitative study to identify determinants of PTSD treatment initiation among 44 U.S. military veterans from the Vietnam and Afghanistan/Iraq wars; half were and half were not receiving treatment. Participants described barriers to and facilitators of treatment initiation within themselves, the post-trauma socio-cultural environment, the health care and disability systems, and their social networks. Lack of knowledge about PTSD was a barrier that occurred at both the societal and individual levels. Another important barrier theme was the enduring effect of experiencing an invalidating socio-cultural environment following trauma exposure. In some cases, system and social network facilitation led to treatment initiation despite individual-level barriers, such as beliefs and values that conflicted with help-seeking. Our findings expand the dominant model of service utilization by explicit incorporation of factors outside the individual into a conceptual framework of PTSD treatment initiation. Finally, we offer suggestions regarding the direction of future research and the development of interventions to promote timely help-seeking for PTSD.

Posttraumatic Stress Disorder (PTSD) is an anxiety disorder that follows exposure to life-threatening experiences such as war, sexual assault, homicide, vehicular crashes and natural disasters. Characteristic symptoms include distress associated with unwanted trauma-related memories coupled with persistent avoidance of reminders of the trauma, diminished responsiveness to the external world, and manifestations of physiological arousal, such as sleep disturbance and hypervigilance (American Psychiatric Association, 1994). Interpersonal, legal, housing, and occupational problems are well known and have deleterious effects on the sufferer, the sufferer's family, and his or her community (Solomon & Davidson, 1997). Individuals who spontaneously recover from

Nina A. Sayer, PhD, Michele Spoont, PhD, and *Maureen Murdoch, MD*, are affiliated Center for Chronic Diseases Outcomes Research, Veterans Affairs Medical Center in Minneapolis Minnesota and with University of Minnesota, Twin Cities Campus. *Greta Friedemann-Sanchez, PhD,* is also affiliated with the University of Minnesota. *Louise E. Parker, PhD*, is an independent consultant in Cambridge, Massachusetts. *Christine Chiros, PhD,* is affiliated with the VA Medical Center, Mental and Behavioral Health Section, in Minneapolis. *Robert Rosenheck, MD,* is with the Northeast Program Evaluation Center (NEPEC), Connecticut VA Healthcare System, in West Haven, Connecticut.

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PTSD usually do so in the first three months (Solomon & Davidson, 1997), but nearly one-third of persons with PTSD never fully recover, even after many years (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

Although there are effective treatments for PTSD (American Psychological Association, 2004; VA/DoD Clinical Practice Guidelines Working Group, 2003), many PTSD sufferers wait years to decades before they seek professional help, if they seek it at all (Sayer, Clothier, Spoont, & Nelson, 2007; Sayer, Spoont, & Nelson, 2004; Wang, Lane, Olfson, Pincus, Wells, & Kessler, 2005). This pattern of unmet treatment needs is not unique to people with PTSD. Indeed, the majority of individuals with common mental disorders do not seek professional help (Kessler, Chiu, Demler, & Walters, 2005; Kessler et al., 1999).

Psychiatric epidemiological studies provide insights into barriers to treatment-seeking for psychiatric disorders. Findings indicate that people who have mental health problems hold beliefs that can inhibit treatment-seeking. These include thinking they do not need treatment, believing treatment will not help, fearing stigmatization, wanting to solve problems on their own, and thinking their problem will go away without treatment (Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2004; Kessler et al., 2001; Leaf, Livingston, Tischler, Weissman, Holzer, & Myers, 1985; Mojtabai, Olfson, & Mechanic, 2002). Many also experience logistical barriers to accessing services that are too far away or costly.

Although informative, an important limitation of these studies is that they used simple, fixed-response checklists to identify barriers to treatment-seeking and did not allow for identification of unspecified variables. More importantly, most of these studies did not examine barriers and facilitators in both treatment-seeking and non-treatment-seeking individuals. Therefore, it remains unclear whether treatment-seeking individuals experience an absence of impediments or whether they experienced the same barriers as their non-treatment-seeking counterparts but were able to overcome them. Moreover, it is unknown whether barriers and facilitators identified for mental health problems in general pertain to PTSD treatment initiation in specific. Finally, these studies have not focused on understanding treatment delay--an important contributor to the problem of unmet need for mental health treatment (Wang, Berglund, Olfson, & Kessler, 2004).

The behavioral model is the dominant framework for examining predictors of health service use. This model considers three sets of factors that affect service utilization: predisposing, enabling, and need (Anderson & Newman, 1973). Predisposing factors are determinants that exist before the onset of an illness that contribute to an individual's propensity to use health care services, such as demographics, social structure, and health beliefs. Enabling resources, such as income and insurance, impede or enhance access to health care. The third factor is need for health care services, operationalized as evaluated (diagnoses or symptom) and perceived need (Anderson, 1995). A number of researchers have applied this model to the study of mental health service use for PTSD (Fikretoglu, Brunet, Schmitz, Guay, & Pedlar, 2006; Koenen, Goodwin, Struening, Hellman, & Guardino, 2003; Rosenheck & Fontana, 1995; Sayer et al., 2007). However, we know of no prior studies examining the utility of this general framework for identification of specific determinants of treatment initiation for PTSD.

Study Context and Purpose

PTSD prevalence is highest among segments of the population with high trauma rates, such as combat veterans. For example, although the twelve-month prevalence of PTSD in the U.S. population is estimated to be less than 4% (Kessler et al., 2005), it is as high as 15% among U.S. combat veterans (Erickson, Wolfe, King, King, & Sharkansky, 2001; Hoge et al., 2004; Kulka et al.,

1990; Sutker, Allain, & Winstead, 1993; Sutker, Uddo, Braidley, & Allain,1993; Sutker, Winstead, Galina, & Allain, 1991). Further, an additional 10% of combat veterans may be experiencing partial PTSD (Kulka et al., 1990; Weiss et al., 1992). Therefore, understanding how and why veterans initiate treatment for PTSD is particularly crucial.

In this article, we describe findings from a qualitative study exploring determinants of PTSD treatment initiation among treatment-seeking and non-treatment-seeking veterans. We selected qualitative methods to identify a broad range of barriers and facilitators that were meaningful to participants. Previous researchers have used qualitative methods to examine help-seeking for psychiatric disorders. Generally, these studies provide information about the stages and dynamic processes involved in seeking help (e.g., Pescosolido, Gardner, & Lubell, 1998). Unlike these other studies, our goal was to identify discrete determinants of PTSD treatment initiation and potential targets for future intervention.

The primary aim of this study was to identify *barriers and facilitators* affecting treatment initiation for PTSD among U.S. veterans from the Vietnam War and the current military operations in and around Afghanistan and Iraq. There have been significant advances in diagnosis and treatment of PTSD since the Vietnam War. By examining barriers and facilitators across veterans from different eras we hoped to increase the generality of our findings. Our second aim was to understand and develop a conceptual framework of PTSD treatment initiation. In particular, we were interested in determining whether the behavioral model of service, so widely used in health services research, was applicable to PTSD treatment initiation.

METHODS

The primary data source was in-depth interviews with veterans who submitted disability claims to the U.S. Department of Veteran Affairs (VA) on the basis of military-related PTSD. Through the act of filing a PTSD claim, participants demonstrated basic awareness of PTSD and a claim of adverse effects. We used a stratified purposeful sampling strategy to obtain variability on key participant characteristics: current mental health treatment status (yes, no), gender, and for men, period of military service. Because of the small number of women who seek PTSD disability benefits (approximately 5%), we recruited women regardless of when they served in the military. The six strata were: female in treatment; Vietnam War male in treatment; Afghanistan/Iraq war male in treatment; female not in treatment; Vietnam War male not in treatment, and Afghanistan/Iraq war male not in treatment.

Participant Recruitment

Staff from the Upper Midwest Veterans Benefits Administration created a log of new PTSD claimants that included veteran contact information, gender, and service era and transferred it to the study team on a monthly basis. The study team sent recruitment materials to men listed as Vietnam or Afghanistan/Iraq war veterans and to all females. Recruitment materials included a cover letter describing the study and asking the receivers to let us know if we could contact them. The project coordinator then called those indicating interest. Of the 220 potential participants, 118 (54%) indicated interest in being contacted, 44 of whom were eligible and interviewed. Reasons for exclusion were: could not be reached (n = 13), refused screening (n = 5), belonged in a stratum (Vietnam) that was filling much quicker than the other strata (n = 37), unclear treatment status (n = 2), male veteran who had not served in the Vietnam or Afghanistan/Iraq war (n = 2), scheduling conflict or distance from VA precluded interview (n = 12), and self-reported positive symptoms of psychosis (e.g., hallucinations, n = 3).

TABLE 1. Interview Topics by Treatment Status

Topic	Treatment Status	
	In Treatment	Not In Treatment
Mental health treatment history	X	X
Facilitators of professional help-seeking (e.g., beliefs, encouragement from any source, ease of access, life events, and circumstances)	X	
Barriers to seeking professional help (e.g., beliefs, discouragement from any source, impediments to getting care, life events, and circumstances)	X	X
Satisfaction with current treatment	X	
Potential facilitators (e.g., what might lead to treatment-seeking or make it easier)	X	X
Help for PTSD from non-professionals (e.g., friends, spiritual or religious counselors, peer-led support groups)	X	X
View of PTSD and PTSD disability benefits	X	X
Closing questions (see if participant has additional information and how she or he experienced the interview process)	X	X

Note. PTSD = Posttraumatic Stress Disorder.

Interview Procedures

The research team developed semi-structured interview guides based on prior research (including studies that used the behavioral model), and the first and third authors' clinical experience. We developed one interview guide for individuals who were in treatment and another for those who were not in treatment. In Table 1, we list the interview topics for each interview guide. Although we covered all topics within each group over the course of each interview, we did not necessarily ask questions using the same wording or in the same order. This allowed us to follow the natural flow of the dialogue. We refined the interview guides over the course of the first few interviews (Crabtree & Miller, 1999; Miles & Huberman, 1994). For example, it became apparent within the first few interviews that treatment-seeking for PTSD was related to the process of applying for PTSD disability benefits. Therefore, we included questions about seeking these benefits. Our semi-structured method also allowed us to investigate additional topics not included in our interview guides but that veterans described as related to their treatment-seeking behavior.

Of the three investigators who conducted each interview, one is an anthropologist with health service research training and two are clinical psychologists with over ten years of experience treating veterans with PTSD and related psychiatric problems. To facilitate intergroup and cross-investigator comparisons, each member of the team interviewed participants from all groups (women, Vietnam, Afghanistan/Iraq) and did so at a similar rate (e.g., we were careful not to finish with one group long before finishing the others). The project coordinator was present during all interviews. Interviews lasted approximately one hour (M = 59 minutes; SD = 17 minutes). The majority took place at the Minneapolis VA Medical Center (n = 40), although the team interviewed four participants with transportation problems who lived within three hours of the VA in their homes. Informed consent was obtained prior to the interview. We conducted interviews over an 18-month period (November, 2005, through June, 2007).

During the course of the interview, the interviewer asked questions to verify her understanding, and the project coordinator asked clarifying questions most commonly at the end of the interview. Upon completion of the interview, the project coordinator ad-

ministered several brief self-report questionnaires: a modified version of a background survey designed for veterans seeking PTSD disability benefits (Sayer et al., 2004), a PTSD symptom inventory (PTSD Checklist; Blanchard, Jones-Alexander, Buckley, & Forneris, 1996; Bliese, Wright, Adler, Cabrera, Castro, & Hoge, 2008; Forbes, Creamer, & Biddle, 2001), the Patient Health Questionnaire--Depression Module (Kroenke, Spitzer, & Williams, 2001), and the Alcohol Use Disorders Identification Test--Consumption Questions (Bush, Kivlahan, McDonell, Fihn, & Bradley, 1998). The three symptom inventories have strong psychometric properties, including criterion-related validity, and have been well-studied in veteran groups (see references listed above). The interviewer and project coordinator completed logs after each interview describing the interview's tenor (e.g., whether the participant talked openly) and summarizing its main themes. We appended the logs to the interview transcripts to facilitate development and interpretation of codes.

Data Analysis

The research coordinator checked verbatim transcripts of the interviews for accuracy and completeness before data analysis. Our interpretive analysis of the content of the interviews began with reviewing the logs and transcripts to develop top-level codes that described broad common themes within the narratives. We then sub-coded quotations linked to the top-level codes for barriers and facilitators affecting treatment initiation. The sub-codes were words or phrases the researchers took from the participants' narratives or chose to reflect participants' experiences. We linked quotations to multiple codes as appropriate. To identify themes and variations in themes across strata, we used inductive and deductive analysis with constant comparison (Glaser & Strauss, 1967). We utilized Atlas.ti V5.0 (Muhr, 2004), a qualitative data management software package, to facilitate the coding and retrieval of illustrative quotes.

Maintaining Research Quality

Each of the three interviewers assigned top-level codes to one-third of the interviews across all groups. Each interviewer then checked another interviewer's top-level coding. We resolved coding discrepancies and reached consensus through face-to-face meetings. The three interviewers and the project coordinator were involved in assigning sub-codes. These four team members assigned sub-codes to 25% of the transcripts across all groups and checked the sub-coding of another sub-coder. Again, we reached consensus through face-to-face meetings. Through this iterative process of coding, checking, and consensus building, the interview team reviewed each transcript four times.

RESULTS

Participants

The sample consisted of 44 veterans. We present participant characteristics in Table 2. We determined treatment status based on participants' perceptions. Most (n = 20) veterans in the in treatment group were receiving specialty mental health treatment; one was receiving what he classified as PTSD treatment from his primary care physician. All male participants were combat veterans. Six of the 14 female participants experienced sexual trauma in the military. Sixty-six percent of the sample exceeded symptom criteria for moderate to severe depression (Kroenke et al., 2001) and 52% were at risk for hazardous drinking (Bush et al., 1998). Sixty-six to 91% of the sample met symptom criteria for probable PTSD, depending on the PTSD Checklist cutoff score used for diagnosis (Blanchard et al., 1996; Bliese et al., 2008; Forbes et al., 2001).

TABLE 2. Participant Characteristics

PTSD Treatment Status *n* (%)	
In Treatment	21 (48)
Service Era *n* (%)	
Afghanistan/Iraq war era	22 (50)
Vietnam era	19 (53)
Other[a]	3 (7)
Gender *n* (%)	
Female	14 (32)
Race n (%)	
White[b]	41 (97)
Marital Status	
Married	20 (45)
Education *n* (%)	
High School	10 (23)
Vocational Training	4 (9)
Some College	22 (50)
College Graduate or Higher	8 (18)
Employment *n* (%)	
Employed	26 (59)
Age years	
M (SD)	42.11 (15.99)
Range	20-62
PTSD Checklist	
M (SD)	55.07 (15.73)
Median	57.00
Minimum	23.00
Maximum	78.00
Patient Health Questionnaire, Depression Module	
M (SD)	12.18 (6.57)
Median	12.00
Minimum	1.00
Maximum	27.00
Alcohol Use Disorders Test, Consumption Questions	
M (SD)	4.52 (4.12)
Median	3.50
Minimum	0.00
Maximum	12.00

Note. *n* = 44. PTSD = Posttraumatic Stress Disorder. [a]Three women served in the military after the Vietnam War but before the Afghanistan/Iraq war. [b]Two of the non-White participants identified as Hispanic and one identified as Native American.

Barriers to Treatment Initiation

Table 3 presents the seven barrier-to-initiation categories and the specific themes within each category. Both participants in treatment and not in treatment described barriers within each category. Barriers had a different level of immediacy and intensity, however, for those who were not in treatment. Participants who were in treatment often described barriers as having caused treatment delays. Below we describe these barriers and provide illustrative quotes from participants across strata.

Trauma-Related Avoidance. Given that persistent avoidance of trauma-related stimuli

TABLE 3. Barrier Themes by Category

1. Avoidance of Trauma-Related Feelings and Memories
2. Values and Priorities That Conflict with Treatment-Seeking
Pride in self-reliance
Focus on job and family functioning
3. Treatment-Discouraging Beliefs
Providers won't understand or believe trauma
Treatment is not helpful
Treatment involves loss of control/autonomy
Treatment is for those who are weak, crazy, or incompetent
Treatment is only for extreme problems
4. Health Care System Concerns
VA and VA providers cannot be trusted
VA has limited resources
VA is for war-fighters from prior wars
VA is for veterans with severe and visible disabilities.
Providers outside the VA do not have expertise in military-related PTSD
5. Knowledge Barriers
Lack of knowledge/understanding of PTSD or services
Lack of knowledge that sexual trauma can cause PTSD
6. Access Barriers
VA enrollment process
Perceived lack of eligibility for VA care without cost
Time constraints
Expense of treatment
Distance and transportation
7. Invalidating Post-Trauma Socio-Cultural Environment
Societal rejection
Negative homecoming experiences
Withdrawal from social network or society
Social network discouragement of help-seeking

Note. PTSD = Posttraumatic Stress Disorder.

is one of the hallmark symptoms of PTSD (Criterion C; American Psychiatric Association, 1994), it is not surprising that participants described avoiding treatment so as to avoid experiencing trauma-related memories and feelings. Participants assumed that PTSD treatment involves discussion of the traumatic experiences that led them to have PTSD. They described fear that such discussion would trigger intense negative feelings and that these feelings might interfere with functioning.

> I don't want to dredge up the past anymore. I'm trying to put that to rest. I've got a good friend buried at Ft. Snelling [cemetery] and after all these years, there's not a week that goes by that I still don't grieve for him. I don't want to dredge that up. [Vietnam War male, not in treatment]

Values and Priorities. Participants discussed values and priorities that reduced their interest in seeking mental health treatment. The most salient value was pride in self-reliance.

Both in treatment and not-in treatment participants preferred to take care of problems on their own and viewed professional help as a last resort.

> Personally, I don't want to talk to a therapist for help reasons--I just want the information, and try and fix it myself first. It's more knowledge of . . . what's going on, how I can fix it . . . and then just a good, stable phone number that if something does come up, and a good feeling that I can get help if I need it, if I can't find out why I'm doing the things I'm doing, or saying the things I'm saying . . . Then, if I feel that need [because] I can't do it on my own . . . I'll go for help. [Afghanistan/Iraq war male, not in treatment]

In addition to valuing self-reliance, participants discussed prioritizing what they perceived as their job functioning or responsibilities rather than their mental health. While on active duty, they prioritized the military mission. After discharge, they focused on reentering family life or participating in their communities as capable adults. For example, one Afghanistan/Iraq war male who was currently in treatment observed that when first discharged, "you're more worried about reconnecting with your wife and child. That kind of stuff [mental health treatment] is just not even part of your thought process." Similarly, a female also currently in treatment reported, "I raised two girls by myself and having the responsibility, I just didn't see the opportunity and didn't think [therapy] was as important as it is."

Treatment-Discouraging Beliefs. Participants described fears and beliefs about mental health treatment in general and PTSD treatment in specific that led them to conclude that treatment would not help or that it was not appropriate for them. One such belief was that providers would not understand their problems or believe their trauma narratives.

> For me, it's really difficult to get to some of the issues that I feel are personal. I never talked about it much with my family, anyway, but then to talk to a total stranger was even harder . . . I think it was the [fear] that if I tell a stranger, how are they going to react? Are they going to believe everything you say? [female, in treatment]

A related treatment fear was that treatment would involve loss of control or of autonomy. For example, according to one female who was not in treatment, "I figured if I told them [mental health professional] how I felt, what I thought . . . that they'd lock me up."

Not surprisingly, the perceived stigma of mental illness discouraged help-seeking. All types of participants observed that both they and the society in general view mental illness negatively. Accordingly, participants expressed fears that other people, including employers and individuals within their social network, would treat them as if they were "weak," incompetent, or "crazy" if they sought help for PTSD. Related to such perceived stigma was the belief that only extremely disturbed people need mental health treatment.

> It took a while to get me into treatment because I had a very negative view at first on getting help . . . I guess it was kind of a view that to see a psychologist was for people who were weak, couldn't take care of themselves, couldn't deal with day to day life. [Afghanistan/Iraq war male, in treatment]

Health Care Systems Concerns. Another barrier to treatment initiation was participants' concerns about the ability of health care systems to meet their needs. In this sample of veterans, most of these concerns were focused on the VA. Some of the themes reflect a stereotyped view of the VA as a system designed for visibly injured, older war fighters with limited financial resources. At the same time, some participants who were not in treatment also expressed the belief that providers outside the VA system would not understand military-related PTSD.

Knowledge Barriers. Participants identified lack of knowledge about PTSD, the types of trauma that can cause PTSD (e.g., sexual trauma), and what services were available as barriers to help-seeking. Lack of knowledge occurred at both the societal and individual levels. Given that PTSD entered the psychiatric nomenclature after the Vietnam War, it is not surprising that lack of knowledge at the societal level was an important barrier theme among Vietnam veterans.

> I don't even think that the medical profession understood it [in the 1970s] . . . And that's unfortunately one of the problems . . . If you don't understand what something is, being able to treat or not treat it is kind of nebulous. [Vietnam War male, not in treatment]

An individual's own lack of knowledge about treatment options and how to access them also interfered with help-seeking, even if the individual had an interest in receiving professional help. For example, this Afghanistan/Iraq war female who was not in treatment explained, "I know that I have this problem [PTSD]. How do I get treated for it? How do I get appropriately diagnosed?... Can I go to any VA? Do I have to go to the VA?"

Access Barriers. Access barriers were organizational and logistical impediments to obtaining help. In this veteran sample, the organizational barriers were VA specific. For example, veterans described the VA enrollment process as time-consuming and complex, and some participants did not know that they were eligible for VA services. Logistical barriers included time, distance, and treatment-related expense. As this female veteran who is not in treatment explained, "I would like to [get help for my PTSD], but I just don't have the money, and it's at least a five-hour drive from where I go to school to either this VA hospital or pretty much [any medical facility]."

An Invalidating Post-Trauma Socio-Cultural Environment. An important barrier theme was the enduring effect of experiencing an invalidating socio-cultural environment following trauma exposure--particularly when the individual perceived the need for help, attempted help-seeking, or attempted to integrate into society following their military deployment. For example, some women with histories of sexual assault while in the military tied lack of help-seeking to a military culture that silenced the reporting of sexual assault.

> When I went in I had this big plan. I was going to be in there 20 years and retire and travel and it didn't happen that way. Instead, I was sexually assaulted the first year and was pretty much told, "If you can't handle it, get out." And then I couldn't talk to anybody about that . . . Nobody wanted to hear it, including the chaplain. [female, in treatment]

Male Vietnam veterans who were not in treatment associated their lack of willingness to seek PTSD services with societal rejection when they were transitioning back to civilian life following their military discharge.

> Part of the problem . . . is that during that whole conflict [Vietnam War] . . . there was so much pain and suffering that was caused by the fractures in the country that . . . I think veterans tended to kind of withdraw within themselves . . . because they . . . didn't know how other people perceived them.

Facilitators of Treatment-Seeking

Table 4 presents the four facilitator-to-initiation categories and the specific themes within each category. Although those not in treatment described potential facilitators, these descriptions had less depth and immediacy than descriptions of actual facilitators among those in treatment. Therefore, all the quotes below are from participants who were in treatment.

TABLE 4. Facilitator Themes by Category

1. Recognition and Acceptance of PTSD and Availability of Help
2. Treatment-Encouraging Beliefs
Getting help is socially acceptable
Other people's negative views do not matter
Treatment is helpful
The system and those encouraging help-seeking are trustworthy
3. System Facilitation
Procedures to reduce stigma, improve access, and promote PTSD recognition
Veterans Service Officers promote help-seeking
Primary care providers promote help-seeking
Disability examiners promote help-seeking
4. Social Network Facilitation and Encouragement
Spouses or partners
Other family members
Other veterans
Non-veteran peers
Employers

Note. PTSD = Posttraumatic Stress Disorder

Recognition and Acceptance. Participants who were in treatment indicated that recognizing and accepting their problems and that there was assistance available was a crucial first step in getting help for their PTSD.

> I think it's recognizing that you have problems. Secondly, it's recognizing that there is help for those problems. Thirdly, I think it's respecting the system that helps us and having faith that a psychologist can help me. Plus a great hope. [female, in treatment]

Treatment-Encouraging Beliefs. In treatment veterans described specific beliefs that facilitated treatment initiation. In contrast to the treatment-discouraging beliefs, encouraging beliefs seemed to protect against the widespread public stigma of mental illness. For example, one female veteran of the Afghanistan/Iraq war, currently in treatment observed:

> I think it's [willingness to get help] a multitude of things . . . —the previous history with my father [a Vietnam veteran] and my family. I think my age allows me to have the world experience that mental illness, mental health [problems] are not taboo subjects. I think my education helps me. I have a brother and a sister [who] are diagnosed with bipolar disorder, so...I know that there's help out there for people with mental illness. The military did . . . an excellent job while we were in country, helping us when we had critical incidents, or at least trying to. I think the clergy that were in the military were better trained for this conflict and [on how] to handle PSTD. It wasn't the taboo subject that my father went through from Vietnam. And I think it's a different generation.

System Facilitation. We use the term "system facilitation" to refer to the active role the health care and disability system played in fostering help-seeking. Some participants discussed the procedures that reduced the effort and stigma associated with help-seeking. In particular, Afghanistan/Iraq war veterans described strategies the military has implemented to foster help-seeking, such as screening, a web-based referral system, and on-site services.

> They did have the psych [sic.] come down to our little camp area . . . and [he] did some sessions down there, so it made it easier for Marines to go see him, instead of going clear across base to see him . . . They had the signs posted up saying, "Psychiatrist here, just come in and talk." And just having other Squad Leaders and Platoon Sergeants and Platoon Commanders and Company COs [Commanding Officers] talking more about it...mentioning to his Marines or soldiers that, "If you're having problems go ahead and seek help because it's nothing to be ashamed of." [Afghanistan/Iraq war male, in treatment]

Participants also discussed how clinical staff, in particular primary care providers, encouraged and referred them to mental health treatment. In some cases, it was the trusting relationship with the primary care provider that eventually led the veteran to follow this recommendation. In addition, participants also reported that contact with staff involved in the VA disability system (e.g., Veterans Service Officers who help veterans obtain benefits and disability examiners) encouraged them to seek treatment and helped them navigate the enrollment process.

Social Network Facilitation and Encouragement. Members of veterans' social networks (i.e., spouses or partners, family members, other veterans, non-veteran peers, and employers) often played a key role in getting participants into treatment in several ways. These include providing encouragement, helping veterans recognize PTSD, motivating veterans to seek assistance, helping them find resources and providers, and even helping them schedule and obtain appointments. Among the various members of the veterans' social networks, the facilitative role of spouses and other veterans was particularly salient. For example, Vietnam veterans were instrumental in promoting help-seeking among Afghanistan/Iraq war veterans. For some, this facilitation led to treatment-seeking despite individual-level barriers, such as lack of recognition and acceptance, lack of knowledge, and treatment-discouraging beliefs.

> Yeah, it wasn't really me. I didn't make the choice. I mean, I suppose I did by actually going in, but it was really for my wife and daughter because I've been dealing with other problems as well throughout my life and I just kind of looked at it all like, "Suck it up. Drive on. I've dealt with this other crap, I can deal with this." But with them keeping on saying, "Go get help," that's what made me do it. [Afghanistan/Iraq war male, in treatment]

DISCUSSION

Both those who were and those who were not in treatment for PTSD described factors that hindered their help-seeking, including their own values, priorities, beliefs, concerns, trauma-related avoidance, lack of access, and an invalidating post-trauma environment. Surprisingly, there were few differences in the types of barriers described by those in treatment and those who were not in treatment. These barriers persisted for those who were not in treatment, giving the barriers particular salience for participants in this group. For some participants, however, facilitators located within the health care system and veteran's social network led to help-seeking despite individual-level barriers, such as treatment-discouraging beliefs. This finding suggests that factors outside the individual can promote mental health service use for PTSD, even when the individual is reluctant.

Many of our findings are consistent with prior research. For example, prior studies have found that problem recognition and perceived need are important precursors to help-seeking and that health beliefs are associated with mental health treatment participation (Kessler et al., 2001). Our finding that pride in self-reliance and perceived stigma inhibiting help-seeking is also in keeping with research demonstrating that individu-

als, including those who served in the current wars, want to solve their own problems and worry about stigmatization (Greene-Shortridge, Britt, & Castro, 2007; Hoge et al., 2004; Kessler et al, 2001; Stecker, Fortney, Hamilton, & Ajzen, 2007). Our study adds to this literature and offers information about specific beliefs and concerns among U.S. veterans with possible PTSD that may affect their help-seeking behaviors and that investigators can examine further in future studies.

New is our finding that the post-trauma socio-cultural environment influences help-seeking for trauma-related psychiatric problems. Although research has established that homecoming experiences predict PTSD symptom levels among male and female Vietnam veterans (Fontana & Rosenheck, 1994; Fontana, Schwartz, & Rosenheck, 1997) and many have considered its relationship to the development of PTSD itself (Johnson, Lubin, Rosenheck, Fontana, Southwick, & Charney, 1997), we know of no prior studies suggesting that negative community integration experiences deter veterans from seeking PTSD treatment. This may help explain why many Vietnam veterans have delayed treatment-seeking for PTSD. As this male Vietnam veteran who is considering treatment explained, "Now it's accepted--the stress thing . . . When I was in, we were told . . . this is the way it is and you don't have a problem, it's not accepted." Findings concerning the importance of the post-trauma socio-cultural environment at the time of community integration may also be applicable to refugees world-wide who face a range of potential post-migration stressors. Researchers examining mental health service use among refugees may want to examine their resettlement experiences.

Our finding that social networks facilitated treatment initiation is consistent with the work examining the influence of social networks on help-seeking (Pescosolido, 1992; Pescosolido et al., 1998). It may also help explain why a prior study found that married PTSD claimants were more likely to be in treatment than those who were not married (Sayer et al., 2007). PTSD in veterans affects not only the veteran sufferer but also spouses and families (Goff et al., 2006; Taft, Vogt, Marshall, Panuzio, & Niles, 2007; Westerlink & Giarratano, 1999). It stands to reason that those whose lives the sufferers' PTSD affects may be motivated to facilitate the veterans' help seeking.

Other studies have identified factors at the health care system level that affect participation in mental health treatment, including static variables such as cost and distance (Rosenheck & Stoler, 1998), as well as care processes such screening programs (e.g., Wang et al., 2007). Although we know relatively little about the role of providers in facilitating mental health treatment participation, researchers in one study observed a positive relationship between provider support and service use among mentally ill homeless individuals (Lemming & Calsyn, 2004). There is more speculation than research on the relationship between participation in a disability program and treatment behavior (cf. Spoont, Sayer, Nelson, & Nugent 2007). Among this sample of veterans, however, we found that participation in the VA disability program promoted treatment-seeking for PTSD. In a subsequent paper based on these interviews, we will explore the complex issues at the intersection of disability- and treatment-seeking.

We can place most of the categories identified through this study within the behavioral model of service use (Anderson & Newman, 1973). For example, we can conceptualize values, priorities, beliefs and VA concerns as predisposing factors and access-limiting barriers, system and social network facilitation as enabling factors. Recognition and acceptance of PTSD is consistent with perceived need. Two barrier categories (invalidating post-trauma environment and trauma-related avoidance), however, do not fit neatly into this framework. According to the behavioral model, symptoms are "needs" and thus should lead to service use (Andersen, 1995). Our findings suggest, however,

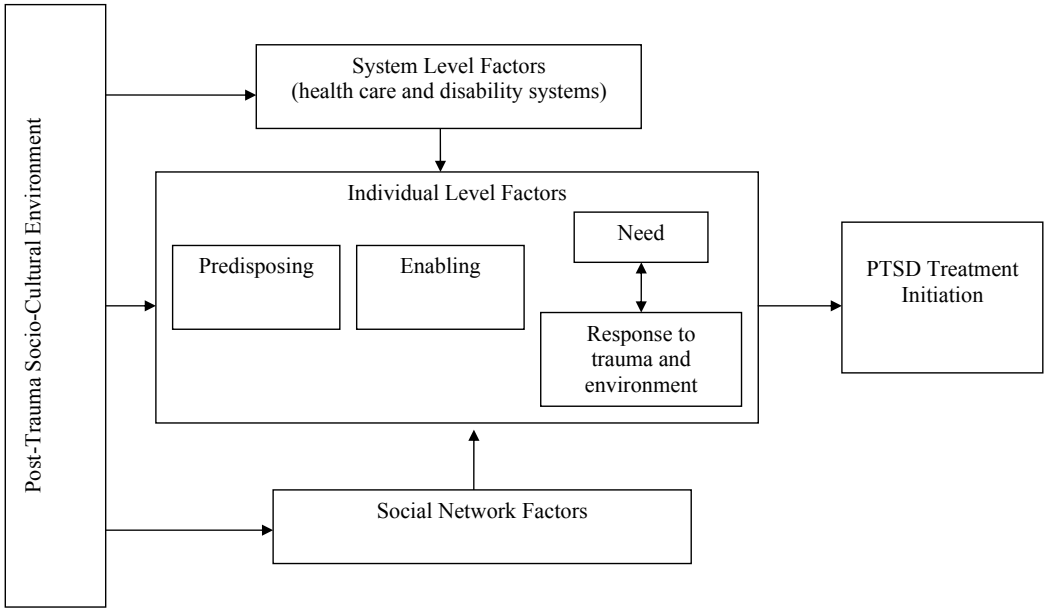

FIGURE 1. Model of PTSD Treatment Initiation

that one PTSD symptom cluster, psychological avoidance, inhibits rather than facilitates treatment initiation. Because the behavioral model is a general framework for studying service use (Andersen, 1995), it is not surprising that specific trauma-related barriers do not fit neatly within it. A model of PTSD treatment initiation should include responses to trauma and the post-trauma environment.

An important finding from this study is that socio-cultural, social network, and system-level factors play an important role in determining PTSD treatment initiation among veterans. Although the pioneer of the behavioral model did not intend for researchers or policy makers to ignore "environmental" variables (Andersen, 1995), the most widely used version of the behavior model lends itself to a focus on individual-level factors. To advance research on PTSD treatment initiation, we propose explicit integration of factors outside the individual into a conceptual framework of PTSD treatment initiation (see Figure 1). The implication of this is that researchers should examine factors at the social network, environmental, and health and disability system levels even if the individual is the unit of analysis. For example, survey items could assess whether spouses and other members of the social network encouraged and facilitated help-seeking and determine the individual's experience of the socio-cultural environment at critical time points following trauma exposure as well as his or her experience of the relevant health care and disability systems. Based on this study, we believe that commonly used measures of predisposing factors, such as race and marital status, and of enabling factors, such as insurance, income, and supportive relationships, are not sufficient indicators of social network or health care system facilitation. In Table 5, we list the identified determinants of PTSD treatment initiation at the various levels of analysis included in our conceptual model.

This model and the barriers and facilitators that our participants described suggest targets for intervention. At the individual

TABLE 5. Determinants of PTSD Treatment Initiation by Level of Analysis

System-Level
Knowledge
Procedures to reduce stigma, promote recognition, and improve access
Behaviors of staff working in health care and disability systems
Enrollment procedures
Location of services
Cost of services
Post-Trauma Socio-Cultural Environment
Politics
Homecoming (e.g., acceptance versus rejection)
Norms
Validation of trauma survivor versus rejection or blame
Validation of help-seeking versus stigma or discouragement
Social Network-Level
Behavior of spouse, partners, family, peer groups, employers
Individual-Level
Predisposing Characteristics
Values and priorities
Beliefs about treatment
Beliefs about mental illness and PTSD
Beliefs about health care systems
Enabling Resources
Knowledge
Insurance
Eligibility
Income
Time for travel and appointments
Transportation
Need for Treatment
Problem recognition and acceptance
Evaluated need
Response to Trauma and Socio-Cultural Environment Following Trauma
Avoidance of trauma-related feelings and memories
Withdrawal from social network or society versus integration

level, we identified beliefs and concerns that future educational initiations could target to promote help-seeking post-deployment. For example, beliefs that mental health treatment is only for extreme problems may be modifiable. Lack of knowledge is also modifiable, although findings based on this sample suggest that efforts to educate veterans about PTSD and services may have limited success while the veterans have other priorities, such as reintegrating back into their communities. In addition, our findings indicate that interventionists may want to include members of a veteran's social network and the public as targets for intervention to reduce stigma and promote early help-seeking. This research further suggests that interventions that encourage self-reliance are particularly likely to be acceptable, at least among veterans. Last, these findings point to the importance of the post-trauma environment and the role of system-level facilitation. Since the beginning of conflicts in Afghanistan and Iraq, the VA and the U.S. Department of Defense (DoD) have made concerted efforts to normalize post-combat adjustment problems and help-

seeking and to improve problem recognition and access to services. Based on our findings regarding the importance of system-level facilitators and the post-trauma socio-cultural environment, these are likely to be effective strategies for fostering PTSD treatment initiation.

Results from this research also suggest that some groups of individuals may be particularly unlikely to seek professional help for PTSD because of their circumstances or experiences. These are individuals without extensive or supportive social networks and those who do not perceive relevant system and societal validation regarding their trauma, such as Vietnam veterans and women with histories of military sexual trauma. Interventionists may need to tailor outreach strategies specifically for individuals whose histories and social contexts do not foster help-seeking.

The study has a number of limitations. First, we interviewed 44 military veterans filing PTSD disability benefit claims in one region of the U.S. Upper Midwest. In keeping with the demographics of this region, most participants identified as White. More research is needed to determine whether findings based on this limited sample generalize to other veteran and nonveteran groups. We do not know whether veterans from other regions and nations or those of different racial and ethnic backgrounds would have identified other themes or a different set of relationships among the themes than those observed in this sample. Additionally, U.S. veterans who are not seeking PTSD disability benefits may identify other types of barriers and facilitators. Furthermore, the attitudes, beliefs, and experiences of veterans may not generalize to non-military populations.

Second, findings reflect participants' views of the factors that helped and hindered their treatment-seeking. Self-presentation and memory biases may have influenced our results just as they might influence the results of any self-report study. Unfortunately, interviews with family members and providers were beyond the scope of this study. We recommend that future studies on treatment initiation collect data from various sources, including not just PTSD sufferers, but also members of their social networks and key informants within relevant institutions. For U.S. veterans these institutions would include the VA, DoD, and Veterans Service Organizations.

These limitations notwithstanding, our findings have implications for the conceptual framework used to study determinants of PTSD treatment initiation, the design of future studies, and the development of interventions to promote timely help-seeking for PTSD. A particular advantage to this study is that we examined both barriers to and facilitators of treatment initiation in a sample of users and non-users, providing us with new insights about factors that may promote help-seeking even when barriers are present. We hope that these findings serve as a springboard for future studies examining the complex interplay between individual, sociocultural, social network and system-level factors that influence help-seeking for PTSD.

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